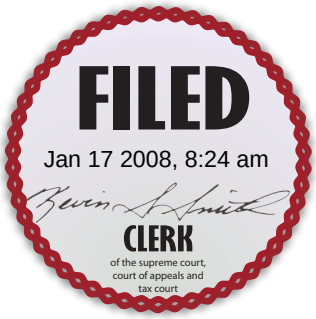

ATTORNEY FOR APPELLANT:

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IN THE
COURT OF APPEALS OF INDIANA

IN RE: COMMITMENT OF M.P.,	)	
	)	No. 57A03-0708-CV-407
Appellant-Respondent.	)	

APPEAL FROM THE NOBLE SUPERIOR COURT
The Honorable Robert E. Kirsch, Judge
Cause No. 57D01-0707-MH-051

January 17, 2008

MEMORANDUM DECISION - NOT FOR PUBLICATION

BAKER, Chief Judge

Appellant-respondent M.P. appeals the trial court's orders requiring that she be involuntarily committed for up to ninety days and involuntarily medicated subject to a thirty-day review. M.P. argues that she should have been permitted to seek an independent psychological evaluation and that there was insufficient evidence supporting the trial court's decision. Finding no error, we affirm.

FACTS

In January 2007, M.P. was diagnosed with colon cancer. She had surgery to remove fifteen inches of her colon and began chemotherapy treatment in April 2007. At some point thereafter, her husband, D.P., began to notice personality changes. Specifically, she refused to admit that she had cancer, became agitated, and became physically abusive to D.P. and verbally aggressive to other people.

On July 30, 2007, the trial court entered an order of emergency detention based on D.P.'s allegations. Thereafter, the sheriff arrived at her home, placed her in handcuffs, and transported her to an inpatient treatment center for a seventy-two-hour detention. Upon her arrival, Dr. Francis Cyran, a staff psychiatrist, examined her and eventually diagnosed her with "[p]sychosis not otherwise specified." Tr. p. 7. He arrived at the diagnosis after learning of D.P.'s allegations and spending fifteen minutes with M.P. On August 2, 2007, a petition was filed seeking temporary commitment and involuntary medication of M.P. The trial court held a hearing on the petition on August 6, 2007, and during the eight days that

elapsed between July 30 and August 6, the only further contact Dr. Cyran had with M.P. was when he saw her at the nurses' station and in the dayroom.

Dr. Cyran participated telephonically in the August 6, 2007, hearing, and he explained the situation as follows:

> Well, in her situation she has no history of mental illness that I know of prior to this year and, uh, which is unusual for a psychotic mental disorder to start at her age. . . . [B]ut for some reason she has become very paranoid of about her husband and neighbors . . . . Such as, uh, she believes she had a [sic] appendicitis, that some of her eggs were stolen, that she has six babies that she needs to find, there are multiple delusional belie[fs], uh, in addition to that she has been very verbally if not physically aggressive with the staff here. She was asked to attend a staffing so that we could talk to her the other day, uh, her response to the staff member was, shove it up your ass, uh, not cooperating with taking medication, at one point, on a couple of occasions throwing the phone at one point at a staff member, stepping on [a] staff member[']s foot, attempting to open the door into the staff member. Behavior of that sort but not really being able to understand that she has been behaving differently and aggressively and that her behavior is not acceptable and always putting it back to a theory that this is her husband trying to break her down for whatever reason.

Id. at 7-8. Dr. Cyran also explained that M.P. questions her colon cancer diagnosis.

Additionally, Dr. Cyran testified that medical professionals were concerned that there might be a medical condition, such as a tumor, causing M.P.'s mental deterioration. Thus, they sought to perform a CAT scan or MRI of M.P.'s brain to ensure that she did not have a brain tumor. M.P., however, refused to cooperate and as a result, the scans were not performed. Dr. Cyran stated that he hoped that after M.P. had been on the proper medication for a short period of time, she would permit the doctors to perform the scans.

Moreover, Dr. Cyran testified that he was aware that M.P. was undergoing chemotherapy and had reviewed information on the type of drugs she had been receiving. Additionally, his staff had been in contact with her oncologist's office.

After hearing testimony from Dr. Cyran, D.P., and M.P., the trial court ordered her to be committed for up to ninety days and to be medicated with antipsychotic drugs suggested by Dr. Cyran. On August 22, 2007, M.P. was discharged from inpatient treatment.[1] M.P. now appeals.

DISCUSSION AND DECISION

When reviewing a challenge to the sufficiency of the evidence supporting the involuntary commitment of an individual, we look to the evidence most favorable to the trial court's decision and draw all reasonable inferences therefrom. Golub v. Giles, 814 N.E.2d 1034, 1038 (Ind. Ct. App. 2004). In reviewing the trial court's decision, we may neither reweigh the evidence nor judge the credibility of witnesses. Id. If the trial court's commitment order represents a conclusion that a reasonable person could have drawn, we will affirm the order even if other reasonable conclusions are possible. Id.

I. Commitment

In temporary commitment proceedings, the burden falls on the petitioner to prove by clear and convincing evidence that the individual is mentally ill and either dangerous or

[1] Because M.P. has been discharged, this matter would ordinarily be moot. But such cases may be decided on their merits where they involve questions of great public interest that are likely to recur or where the rights of an individual are involved. Golub v. Giles, 814 N.E.2d 1034, 1036 n.1 (Ind. Ct. App. 2004). How individuals subject to involuntary commitment are treated by our trial courts is one of great importance to society, id.; therefore, we will address M.P.'s claim regarding her involuntary commitment.

gravely disabled. Ind. Code § 12-26-6-1. For the purpose of a temporary civil commitment, "mental illness" is defined as "a psychiatric disorder that: (A) substantially disturbs an individual's thinking, feeling, or behavior; and (B) impairs the individual's ability to function." Ind. Code § 12-7-2-130(1).

Here, the trial court and Dr. Cyran engaged in the following discussion regarding M.P.'s mental state:

> Court: And, is there a substantial impairment or obvious deteroration [sic] in [M.P.'s] judgment, reasoning or behavior that results in her ability to function independently?
>
> Dr. Cyran: Yes, I believe there is a deterioration of that sort. I don't believe that she can function independently. She does not acknowledge her medical condition for which she needs treatment.

Tr. p. 9. This evidence is sufficient to establish that M.P. was mentally ill according to the relevant statutory definition.

Dr. Cyran also testified that in his opinion, M.P. was dangerous:

> She is, I mean I believe she is definitely a danger to her husband. She says that, uh, when I asked her about her physical aggression, she says, "I have every right to hit him, he is driving me nuts". So, she is dangerous to him. I also think that her behavior in accusing people of things, being very angry and verbally aggressive may lead to some kind of altercation in the community whether either she or someone else could get hurt too.

Id. This evidence is sufficient to establish that M.P. was dangerous. Inasmuch as the evidence established that M.P. was mentally ill and dangerous, the trial court did not erroneously order that she be temporarily committed for up to ninety days.[2]

II. Medication

Next, M.P. argues that the trial court erroneously ordered that she be involuntarily medicated. Our Supreme Court has observed that Indiana "recognizes a right to refuse treatment until the proposed treatment plan has been judicially reviewed . . . ." In re M.P., 510 N.E.2d 645, 646 (Ind. 1987). Due process requires that the trial court conduct a hearing to evaluate the competing interests of the individual and the State and, "[a]t that hearing, the State has the burden of proof, by clear and convincing evidence, to establish the necessity of medication with anti-psychotic drugs." Id. at 647 (internal citation omitted). Specifically,

> the State must demonstrate by clear and convincing evidence that: 1) a current and individual medical assessment of the patient's condition has been made; 2) that it resulted in the honest belief of the psychiatrist that the medications will be of substantial benefit in treating the condition suffered, and not just in controlling the behavior of the individual; 3) and that the probable benefits from the proposed treatment outweigh the risk of harm to, and personal concerns of, the patient. At the hearing, the testimony of the psychiatrist responsible for the treatment of the individual requesting review must be presented and the patient may present contrary expertise.

Id. The M.P. court went on to describe "the following three limiting elements":

> First, the court must determine that there has been an evaluation of each and every other form of treatment and that each and every alternative

[2] M.P. also argues that she was entitled to a psychiatric evaluation by an independent professional not associated with the inpatient center. While that may be true, M.P. neither requested such an evaluation nor sought a continuance to enable her to find a doctor to conduct an evaluation. Under these circumstances, we can only conclude that she has waived this argument.

> form of treatment has been specifically rejected. It must be plain that there exists no less restrictive alternative treatment and that the treatment selected is reasonable and is the one which restricts the patient's liberty the least degree possible. Inherent in this standard is the possibility that, due to the patient's objection, there may be no reasonable treatment available. This possibility is acceptable. The duty to provide treatment does not extend beyond reasonable methods. Second, the court must look to the cause of the commitment. Some handicapped persons cannot have their capacities increased by anti-psychotic medication. The drug therapy must be within the reasonable contemplation of the committing decree. And thirdly, the indefinite administration of these medications is not permissible. Many of these drugs have little or no curative value and their dangerousness increases with the period of ingestion. The court must curtail the time period within which they may be administered. If a patient does not substantially benefit from the medication, it should no longer be administered.

Id. at 647-48.

Here, at the hearing, the trial court and Dr. Cyran engaged in the following discussion regarding the possibility of involuntarily medicating M.P.:

> Court: And, what medication are you recommending to the Court that she take?
>
> Dr. Cyran: Well, if she will cooperate and take medication orally I would recommends [sic] a medication called Invega, which is a medicine that is an anti-psychotic and can be used as a mood stabilizer as well, uh, but given her lack of cooperation I would probably recommend that we go with a long acting injectable [sic] medication such as Prolix Deconate and that we get that started with an injection every week or two.
>
> Court: All right. Is there an alternative treatment other than psychiatric medication that would be a possibility?
>
> Dr. Cyran: Well, the psycho therapy [sic] and group therapy are an important part of treatment, but they are not going to be effective without medication. So, medication is

a necessary part of the treatment no matter what else you do.

Court: And, in your opinion will medication be of substantial use and benefit in treating the underlying condition?

Dr. Cyran: Yes, I believe it will.

Court: And, in your opinion does [sic] the probable benefits of the medication outweigh the risks of side effects and the personal concerns that [M.P.] might have?

Dr. Cyran: Yes, it does.

***

Court: And, what is your prognosis without treatment?

Dr. Cyran: The prognosis is poor.

***

Court: Okay. What is your prognosis with treatment?

Dr. Cyran: The prognosis is pretty good because this illness came on suddenly late in life and medication probably could make a big difference in bringing her back to her normal mental state.

Court: Have you ruled out or have you looked at any medical conditions, organic conditions that might be causing this problem?

Dr. Cyran: Uh, that is a concern. . . . [M.P.] was not cooperative with [a physical examination] which would have included a CAT scan or MRI scan of the brain to make sure that this is, uh, that we are not dealing with some kind of organic brain problem possibly related to her colon cancer.

Court: Okay. So do you think that if you got her on medication at some point in time if she became compliant that you would try to get one of those, a CAT scan or MRI?

Dr. Cyran: Oh, yes, definitely.

Tr. p. 10-11, 12, 13-14. The trial court's medication order provides as follows:

1. There exists no less restrictive alternative treatment;

2. The treatment selected is reasonable and within the contemplation of the committing degree; and

3. The treatment is one which restricts the individual's liberty in the least degree possible.

4. Request for Court Ordered medication is granted.

5. The Court orders the following medications may be administered:

   a. Invega

   b. Prolixin Decanoate (injection)

6. The administering of medications shall be in dosages which are least potentially harmful to the Respondent. The medications shall be discontinued if the Respondent shows any serious signs of side effects.

7. The head of the facility, his designee or the attending physician is directed to submit a report to the Court within 30 days.

Medication Order (attached to Appellant's Brief).

We now turn to the three limiting elements described in M.P., the first of which is that the trial court "must determine that there has been an evaluation of each and every other form of treatment and that each and every alternative form of treatment has been specifically rejected." 510 N.E.2d at 647. As set forth above, Dr. Cyran considered the possibility of psychotherapy and group therapy, but concluded that those forms of treatment would be ineffective if not accompanied by medication. And as to the medication itself, Dr. Cyran recommended an oral medication, but noted that if M.P. resisted taking that type of

medication, he recommended that she be injected with a different type of drug. We find that this evidence clearly establishes that Dr. Cyran and the trial court evaluated and rejected every other possible form of treatment.

Second, the trial court must examine the cause of the commitment to ensure that the drug therapy will be an effective tool. Id. at 648. Here, the trial court asked Dr. Cyran whether there could be an underlying, organic condition causing M.P.'s altered mental state. The psychiatrist responded that yes, the physicians were concerned about the possibility of a brain tumor but that M.P. refused to undergo the necessary scans. In Dr. Cyran's opinion, the temporary involuntary medication of M.P. would at least cause her to cooperate with the scans so that it could be determined whether she had a brain tumor or other organic condition causing the mental difficulties. We find that this evidence clearly establishes that the trial court evaluated whether the medication was within the reasonable contemplation of the committing degree.

Finally, the indefinite administration of antipsychotic medications is not permissible. Here, although the medication order did not include a definite end point, it did require Dr. Cyran or another professional involved with M.P.'s treatment to submit a report to the trial court within thirty days of the entry of the order. Presumably, when that report was submitted, the trial court was able to reevaluate its order and act accordingly. By providing a definite endpoint at which the medication order was to be reviewed, the trial court sufficiently avoided the prohibition against the indefinite administration of antipsychotic medications. Cf. J.S. v. Center for Behavioral Health, 846 N.E.2d 1106, 1116 (Ind. Ct. App.

2006) (finding that trial court's medication order, which did not specify a deadline for the forced administration of medication, was not indefinite because there is a yearly statutory review requirement that exists regardless of whether the trial court's order mentions it), trans. denied. Under these circumstances, we find that the trial court properly ordered that M.P. be involuntarily medicated subject to a thirty-day review.

Finally, M.P. argues that the trial court overlooked evidence that Dr. Cyran had failed to contact her oncologist to determine whether the chemotherapy she had been receiving could have caused her aberrant behavior or whether the antipsychotic drugs could have potentially dangerous or damaging interactions with the chemotherapy. Initially, we note that Dr. Cyran testified that he was aware that M.P. had been undergoing chemotherapy and that he had reviewed some information about that medication. He concluded, based on his review, that the chemotherapy was not the cause of M.P.'s mental condition. Tr. p. 15. Furthermore, Dr. Cyran's staff had, in fact, contacted the oncologist. Id. at 16. Finally, the trial court assured M.P. that it would "call Dr. Cyran and ask to make sure that he checks with Fort Wayne Oncology to make sure that he is coordinating with them." Id. at 35. This evidence establishes that Dr. Cyran and the trial court were aware of M.P.'s chemotherapy and intended to coordinate appropriately with her oncologist. M.P. could have called her oncologist as a witness at the hearing if she wanted more specific information about her chemotherapy treatment to be a part of the trial court's evaluation, but she did not do so. Thus, we do not find that the trial court erred in this regard.

The judgment of the trial court is affirmed.

DARDEN, J., and BRADFORD, J., concur.